Adopted	Rejected

COMMITTEE REPORT

YES: 8
NO: 4

MR. SPEAKER:

Your Committee on ***Insurance, Corporations and Small Business*** *, to which was referred House Bill 1128 , has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill* ***be amended*** *as follows:*

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 16-21-2-16 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004]: **Sec. 16. (a) Before admitting a patient, a hospital shall notify the patient that the patient should verify that services provided by health care providers in the hospital are covered under the patient's health insurance plan.**

(b) A hospital shall:

(1) conspicuously post a sign in the area in which patients are admitted; or

(2) provide written notice to a patient;

in language specified by the department of insurance to notify patients of the need to verify that services provided by health care

providers in the hospital are covered under the patient's health insurance plan.

SECTION 2. IC 16-21-3-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004]: **Sec. 4. (a) A hospital or an ambulatory outpatient surgical center shall not attempt to collect payment for services from a patient until the hospital or ambulatory outpatient surgical center, in compliance with IC 27-8-5.7 and IC 27-13-36.2, exhausts reasonable means of collecting payment for the services from the patient's insurer or health maintenance organization.**

(b) A hospital or an ambulatory outpatient surgical center that collects payment for services from a patient shall reimburse the patient for any amount of the payment collected from the patient that is later paid by an insurer or a health maintenance organization.

(c) A hospital or an ambulatory outpatient surgical center shall repay to the patient described in subsection (b) interest on the amount later paid at the same interest rate as provided in IC 12-15-21-3(7)(A) from the date on which the amount was collected from the patient to the date on which the hospital or ambulatory outpatient surgical center repays the patient.

SECTION 3. IC 16-21-3-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004]: **Sec. 5. A hospital or an ambulatory outpatient surgical center that provides to a patient notice concerning a third party billing for a service provided to the patient shall ensure that the notice:**

(1) conspicuously states, in a font size specified by the department of insurance, that the notice is not a bill;

(2) does not include a tear-off portion;

(3) is not accompanied by a return mailing envelope; and

(4) is not provided to the patient earlier than sixty (60) days after the service is performed.

SECTION 4. IC 16-25-5-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004]: **Sec. 9. (a) A hospice shall not attempt to collect payment for hospice services from a hospice program patient until the hospice, in compliance with IC 27-8-5.7 and**

IC 27-13-36.2, exhausts reasonable means of collecting payment for the hospice services from the hospice program patient's insurer or health maintenance organization.

(b) A hospice that collects payment for hospice services from a hospice program patient shall reimburse the hospice program patient for any amount of the payment collected from the hospice program patient that is later paid by an insurer or a health maintenance organization.

(c) A hospice shall repay to the patient described in subsection (b) interest on the amount later paid at the same interest rate as provided in IC 12-15-21-3(7)(A) from the date on which the amount was collected from the hospice program patient to the date on which the hospice repays the patient.

SECTION 5. IC 16-25-5-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004]: **Sec. 10. A hospice that provides to a hospice program patient notice concerning a third party billing for a hospice service provided to the hospice program patient shall ensure that the notice:**

(1) conspicuously states, in a font size specified by the department of insurance, that the notice is not a bill;

(2) does not include a tear-off portion;

(3) is not accompanied by a return mailing envelope; and

(4) is not provided to the hospice program patient earlier than sixty (60) days after the hospice service is performed.

SECTION 6. IC 16-27-1-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004]: **Sec. 17. (a) A home health agency shall not attempt to collect payment for home health services from a patient until the home health agency, in compliance with IC 27-8-5.7 and IC 27-13-36.2, exhausts reasonable means of collecting payment for the services from the patient's insurer or health maintenance organization.**

(b) A home health agency that collects payment for home health services from a patient shall reimburse the patient for any amount of the payment collected from the patient that is later paid by an insurer or a health maintenance organization.

(c) A home health agency shall repay to the patient described in

subsection (b) interest on the amount later paid at the same interest rate as provided in IC 12-15-21-3(7)(A) from the date on which the amount was collected from the patient to the date on which the home health agency repays the patient.

SECTION 7. IC 16-27-1-18 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004]: **Sec. 18. A home health agency that provides to a patient notice concerning a third party billing for a home health service provided to the patient shall ensure that the notice:**

(1) conspicuously states, in a font size specified by the department of insurance, that the notice is not a bill;

(2) does not include a tear-off portion;

(3) is not accompanied by a return mailing envelope; and

(4) is not provided to the patient earlier than sixty (60) days after the home health service is performed.

SECTION 8. IC 16-28-2-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004]: **Sec. 10. (a) A health facility shall not attempt to collect payment for services from a patient until the health facility, in compliance with IC 27-8-5.7 and IC 27-13-36.2, exhausts reasonable means of collecting payment for the services from the patient's insurer or health maintenance organization.**

(b) A health facility that collects payment for services from a patient shall reimburse the patient for any amount of the payment collected from the patient that is later paid by an insurer or a health maintenance organization.

(c) A health facility shall repay to the patient described in subsection (b) interest on the amount later paid at the same interest rate as provided in IC 12-15-21-3(7)(A) from the date on which the amount was collected from the patient to the date on which the health facility repays the patient.

SECTION 9. IC 16-28-2-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004]: **Sec. 11. A health facility that provides to a patient notice concerning a third party billing for a service provided to the patient shall ensure that the notice:**

(1) conspicuously states, in a font size specified by the department of insurance, that the notice is not a bill;

(2) does not include a tear-off portion;

(3) is not accompanied by a return mailing envelope; and

(4) is not provided to the patient earlier than sixty (60) days after the service is performed.

SECTION 10. IC 25-1-9-19 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004]: **Sec. 19. (a) A practitioner shall not attempt to collect payment for health care services from a patient until the practitioner, in compliance with IC 27-8-5.7 and IC 27-13-36.2, exhausts reasonable means of collecting payment for the services from the patient's insurer or health maintenance organization.**

(b) A practitioner that collects payment for health care services from a patient shall reimburse the patient for any amount of the payment collected from the patient that is later paid by an insurer or a health maintenance organization.

(c) A practitioner shall repay to the patient described in subsection (b) interest on the amount later paid at the same interest rate as provided in IC 12-15-21-3(7)(A) from the date on which the amount was collected from the patient to the date on which the provider repays the patient.

SECTION 11. IC 25-1-9-20 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004]: **Sec. 20. A practitioner that provides to a patient notice concerning a third party billing for a health care service provided to the patient shall ensure that the notice:**

(1) conspicuously states, in a font size specified by the department of insurance, that the notice is not a bill;

(2) does not include a tear-off portion;

(3) is not accompanied by a return mailing envelope; and

(4) is not provided to the patient earlier than sixty (60) days after the health care service is performed.".

Page 1, between lines 4 and 5, begin a new paragraph and insert:

"SECTION 13. IC 27-8-5.7-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004]: **Sec. 4.5. (a) A provider shall file with an insurer a claim for a health care service provided to an insured not more than forty-five (45) days after the health care service is provided. If the insured is covered under more than one**

(1) third party payment source, the provider shall file a claim for the health care service with the secondary payor not more than forty-five (45) days after the primary payor makes payment for the health care service.

(b) A provider that files with an insurer a claim for a health care service provided to an insured may not file with the insurer another claim for the same health care service until a period equal to the applicable time limit for payment of a clean claim under section 6(a) of this chapter has expired since the filing of the first claim.

(c) A provider that has the capacity to file a claim electronically may not attempt to collect payment from an insured for a health care service unless:

(1) the provider has electronically filed in compliance with subsection (b) not less than two (2) claims for the health care service with the insurer; and

(2) a period equal to the time limit for payment of a clean claim under section 6(a)(1) of this chapter has expired since the filing of the second claim.

(d) If a provider violates subsection (c) and the violation has an adverse effect on the insured's credit report, the provider shall take all action necessary to remedy the adverse effect.".

Page 1, line 7, delete "six (6) months" and insert "**two (2) years**".

Page 1, line 8, delete ":".

Page 1, delete line 9.

Page 1, line 10, delete "(2)".

Page 1, run in lines 8 through 10.

Page 1, line 10, delete "the" and insert "**a clean**".

Page 1, line 10, delete "described in subdivision (1)".

Page 1, line 11, delete "the provider" and insert "**a provider**".

Page 1, line 11, delete ";" and insert "**,**".

Page 1, run in lines 11 through 12.

Page 1, line 13, delete "from the provider." and insert "**.**".

Page 1, line 14, delete "Every" and insert "**After December 31, 2003, every**".

Page 2, between lines 5 and 6, begin a new paragraph and insert:

"**(c) This section does not apply if the provider or insured has been charged or convicted of fraud or misrepresentation with**

respect to the claim on which the overpayment was made.".

Page 2, line 8, after "An" insert "**insurer's preauthorization of a health care service remains effective for seven (7) days after the date on which performance of the health care service was proposed at the time of the preauthorization, and the**".

Page 2, line 10, delete "for any reason other than that:" and insert "**during the preauthorization period, unless:**".

Page 2, line 13, delete "unnecessary; or" and insert "**not medically necessary;**".

Page 2, line 15, delete "." and insert "**;**

(3) the health care service was not a covered benefit on the date on which the health care service was performed; or

(4) the information provided to the insurer for payment of a claim for the preauthorized health care service is substantially different from the information provided to the insurer at the time the health care service was preauthorized.".

Page 2, delete lines 16 through 32, begin a new paragraph and insert:

"SECTION 16. IC 27-8-5.8-1, AS ADDED BY P.L.230-2001, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004]: Sec. 1. **(a) Except as provided in subsection (b),** as used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis. The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy.

(5) A limited benefit health insurance policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

(9) A student health insurance policy.

(b) As used in section 5 of this chapter, "accident and sickness insurance policy" means an insurance policy described in subsection (a) that is issued on an individual or a group basis.

SECTION 17. IC 27-8-5.8-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004]: **Sec. 5. An insurer that issues an accident and sickness insurance policy shall include on an insured's insurance benefit card language specified by the department of insurance notifying the insured of the need to verify, before seeking hospital services, that services provided by health care providers in a hospital are covered under the insured's accident and sickness insurance policy.**

SECTION 18. IC 27-13-9-6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004]: **Sec. 6. A health maintenance organization shall include on an enrollee's health maintenance organization benefit card language specified by the department notifying the enrollee of the need to verify, before seeking hospital services, that services provided by health care providers in a hospital are covered under the enrollee's contract with the health maintenance organization.**

SECTION 19. IC 27-13-36.2-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004]: **Sec. 2.5. (a) A provider shall file with a health maintenance organization a claim for a health care service provided to an enrollee not more than forty-five (45) days after the health care service is provided. If the enrollee is covered under more than one (1) third party payment source, the provider shall file a claim for the health care service with the secondary payor not more than forty-five (45) days after the primary payor makes payment for the health care service.**

(b) A provider that files with a health maintenance organization a claim for a health care service provided to an enrollee may not file with the health maintenance organization another claim for the same health care service until a period equal to the applicable time limit for payment of a clean claim under section 4(a) of this chapter has expired since the filing of the first claim.

(c) A provider that has the capacity to file a claim electronically may not attempt to collect payment from an enrollee for a health care service unless:

(1) the provider has electronically filed in compliance with subsection (b) at least two (2) claims for the health care service with the health maintenance organization; and

(2) a period equal to the time limit for payment of a clean claim under section 4(a)(1) of this chapter has expired since the filing of the second claim.

(d) If a provider violates subsection (c) and the violation has an adverse effect on the enrollee's credit report, the provider shall take all action necessary to remedy the adverse effect.".

Page 2, line 36, delete "six (6) months" and insert "**two (2) years**".

Page 2, line 37, delete ":".

Page 2, delete line 38.

Page 2, line 39, delete "(2)".

Page 2, run in lines 37 through 39.

Page 2, line 39, delete "the" and insert "**a clean**".

Page 2, line 39, delete "described in subdivision (1)".

Page 2, line 40, delete "the provider" and insert "**a provider**".

Page 2, line 41, delete ";" and insert "**,**".

Page 2, run in lines 41 through 42.

Page 3, line 1, delete "from the provider." and insert "**.**".

Page 3, line 2, delete "Every" and insert "**After December 31, 2003, every**".

Page 3, between lines 11 and 12, begin a new paragraph and insert:

"**(c) This section does not apply if the provider or enrollee has been charged or convicted of fraud or misrepresentation with respect to the claim on which the overpayment was made.**".

Page 3, line 14, after "maintenance" insert "**organization's preauthorization of a health care service remains effective for seven (7) days after the date on which performance of the health care service was proposed at the time of the preauthorization, and the health maintenance**".

Page 3, line 17, delete "for any reason other than that:" and insert "**during the preauthorization period, unless:**".

Page 3, line 20, delete "unnecessary; or" and insert "**not medically necessary;**".

Page 3, line 22, delete "." and insert "**;**

(3) the health care service was not a covered benefit on the date on which the health care service was performed; or

(4) the information provided to the health maintenance organization for payment of a claim for the preauthorized health care service is substantially different from the information provided to the health maintenance organization at the time the health care service was preauthorized.".

Page 3, delete lines 23 through 40, begin a new paragraph and insert:

"SECTION 22. [EFFECTIVE UPON PASSAGE] **The department of insurance shall, not later than September 30, 2003, adopt rules under IC 4-22-2 specifying language required under:**

(1) IC 16-21-2-16, as added by this act, to be posted in a hospital or provided as written notice by a hospital to a patient notifying the patient of the need to verify that services provided by health care providers in the hospital are covered under the patient's health insurance plan;

(2) IC 27-8-5.8-5, as added by this act, to be included on an insured's insurance benefit card notifying the insured of the need to verify, before seeking hospital services, that services provided by health care providers in the hospital are covered under the insured's accident and sickness insurance policy; and

(3) IC 27-13-9-6, as added by this act, to be included on an enrollee's health maintenance organization benefit card notifying the enrollee of the need to verify, before seeking hospital services, that services provided by health care providers in the hospital are covered under the enrollee's contract with the health maintenance organization.

SECTION 23. [EFFECTIVE UPON PASSAGE] **The department of insurance shall, not later than September 30, 2003, adopt rules under IC 4-22-2 to specify a font size as provided in IC 16-21-3-5(1), IC 16-25-5-10(1), IC 16-27-1-18(1),**

IC 16-28-2-11(1), and IC 25-1-9-20(1), all as added by this act.

SECTION 24. **An emergency is declared for this act.**".

Renumber all SECTIONS consecutively.

(Reference is to HB 1128 as introduced.)

and when so amended that said bill do pass.

Representative Fry